





Kaiser Permanente Allied Healthcare

Scholarship Application

Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in rural and urban areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities.

HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

Application Instructions



The **Kaiser Permanente Allied Healthcare Scholarship** is offered to students enrolled or accepted in an allied healthcare education program. Students who attend a community college program are eligible for a scholarship up to **\$2,000**. Students who attend a university program are eligible for up to **\$2,000**.

Applications for the Kaiser Permanente Allied Healthcare Scholarship are accepted biannually in March and September. Scholarships funded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the student's allied healthcare education. All awards are subject to the availability of funding.

The purposes of the Kaiser Permanente Allied Healthcare Scholarship are: 1) to encourage allied healthcare professionals to practice direct patient care in a medically underserved area of California; 2) to increase the number of appropriately trained allied healthcare professionals; and 3) to encourage underrepresented groups to pursue the allied healthcare profession.

Selection criteria

Selection for the Kaiser Permanente Allied Healthcare Scholarship is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience—allied healthcare and non-allied healthcare work experience in a medically underserved area (MUA).

Financial Need—actual or potential financial difficulty in completing education in the absence of the scholarship.

Career Goals—professional goals for the next five to ten years.

Community Service—documented volunteer service and/or activities, particularly in a MUA.

Community Background—family structure and community where you grew up: for example, rural, inner city/urban, suburban, or MUA.

Priority will be given to:

Students who will complete their allied healthcare program within the next two years.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

Scholarship Eligibility

To be eligible for a scholarship, students must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms: Be enrolled or accepted in one of the following allied healthcare programs: Diagnostic Medical Sonography, Medical Imaging, Medical Laboratory Technology, Occupational Therapy, Pharmacy, Pharmacy Technician, Physical Therapy, Respiratory Care, Social Work, Surgical Technician, Ultrasound Technician; Be a full-time or part-time student (no less than 6 units) in an accredited school; Immediately following graduation, complete a 1-year service obligation to work in a medically underserved area of California providing direct patient care in your field of study

Or

Immediately following graduation, complete 100 volunteer work hours or every \$2,000 scholarship or 150 volunteer work hours for every \$2,500 scholarship.

Maintain a minimum cumulative GPA of 2.0 each year funds are received

Be a U.S. citizen or permanent resident and a California resident.

Scholarship Application

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify students if their application is received incomplete. Students are urged to contact the Foundation prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

Submit the following:

1. One (1) official transcript related to your allied healthcare education. If you are a student in your first year of the program and your transcripts do not reflect your allied healthcare education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

- *Students must also submit two (2) photocopies of their application and 2 photocopies of the following supporting documents (items 2 through 5)
- **2. Personal Statements**. Attach your personal statements to the application. Your statements must be typed. Statements may be short or long. However, please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.
- **3. Two letters of recommendation**. Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.
- **4. Graduation Date Verification Form**. The program director or a faculty member authorized to sign on the director's behalf must sign this form. The Graduation Date Verification Form is enclosed as part of the scholarship application. Students can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.
- **5. Student Aid Report (SAR).** Students must submit the final 2003-2004 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html.

Or

2002 Federal tax return with all W-2s. Students who do not apply for financial aid must submit complete copies of their 2002 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

Notification of awards

The Foundation will notify students of their application results within eight weeks of the final filing date.

Spring Application POSTMARK DEADLINE: March 26, 2003 Fall Application POSTMARK DEADLINE: September 11, 2003

Submit applications to: Health Professions Education Foundation 818 K Street, Suite 210 Sacramento, CA 95814 (800) 773-1669 or (916) 324-6500

Kaiser Permanente Allied Healthcare Scholarship Application

POSTMARK DEADLINE MARCH 26, 2003 AWARDS RANGE: \$2,000 TO \$2,500



PART A – PERSONA (Please type or print your	AL INFORMATION ranswers in the space provided)	List any languages you can speak, read, a to English:	and write in addition Check all that apply.
Do you owe an existing	g service obligation to another entity?	1	
☐ Yes ☐ NO	g service obligation to another entity:	2	Speak Read Write
If yes, please explain.		Are you a citizen or permanent resident o Are you a California resident? Yes	f the U.S.?
		PART B – WORK EXPERIENCE Please list all paid and/or unpaid work exhad. List most recent first. Attach addition	
Are you a previous awa	ardee of the Foundation? Yes NO	Employer's Name	
If yes, please enter the	e contract#:	Address	
		City	
Name		County	
Mailing Address		Your Supervisor's Name: Office Phone:	
City	State Zip	Your Position/title:	
County			_
Permanent Address		Paid worker OR None paid Full-	time OR L Part-time
		Employment Start Date/ Employe	ment End Date//
	·	Average hours worked (please choose only one):	/day/week/month
,		Brief description of your job duties:	
Home Phone	Work Phone		
Social Security #:	CA Drivers License #	_	
Date of birth:/_	/ Age: Gender: Male Female	Employer's Name	
Marital Status: Unma	arried Married	Address	
Number of dependents	other than self and spouse:	City	State Zip
Are you currently empl	loyed as a licensed health professional?	County	
Yes No		Your Supervisor's Name:	Office Phone:
If yes, provide license #	Expiration date/	Your Position/title: I	Monthly Salary:
Are you the first in you	ur family to attend college?	Paid worker OR None paid Full-	time OR Part-time
Which best describes	your ethnic background:	Employment Start Date// Employn	ment End Date//
Asian American	African American Caucasian	Average hours worked (please choose only one):	
Hispanic/Latino	☐ Native American ☐ Pacific Island	der Brief description of your job duties:	
Other (Please specify) _		_	
If Native American, please sp	pecify tribal affiliation:		
	50P.0551	CIAL USE ONLY.	
Recd:	Compl / Inc:	Omitted: A/Pgs GDV EVF SAR TAX LOR	Oth:
Applnguiry: (-) ()	HPEF Contact: for:	
Input by:	MUA: Yes / No	CT#	
Reviewed By:		Comments:	

Kaiser Permanente Allied Healthcare Scholarship Application

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PART C - COMMUNITY BACKGROUND

For each age category below, list the city, county, and state you grew up in. Check all

			ackground.		
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
Birth-10 years					
City: Age Category	Rural	County: Inner City/Urban	Suburban	Poor	State: Middle-class
					Wildule-Class
10-20 years		County:			State:
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
20-30 years					
City:		County:			State:
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
30-40 years					
City: Age Category	Rural	County: Inner City/Urban	Suburban	Poor	State: Middle-class
40+ years	nurai				Wildule-Class
City:		County:			State:
PART D — QUESTIONNAIRE Where did you hear about the Kaiser Permanente Allied Health Program? (Check all that apply)					
School Work (employer or co-worker) Friend/Acquaintance					
Foundation Web site Other Web site Advertisement TV Radio					
Newspaper or publication (please specify)					
Organization or Affiliation (please specify)					
Other source (please specify)					
Where did you receive the Kaiser Permanente Allied Health Program application form? (Check only one.)					
☐ Financial Aid Office ☐ Program Director/Instructor ☐ Foundation office					
Foundation Web site Other Web site Work (employer/co-worker)					
L Foundation					
Friend/Acqu					
Friend/Acqu	uaintance				

PAKI **E** – **Personal Statements**

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

- 1. What kind of work do you think you'll be doing in five years?
- 2. What is your vision of you professional future in ten years?
- 3. Describe any community service, volunteer activities, or club memberships within the past two years (Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.):
- 4. Briefly describe your family background including: your father's and mother's occupation, annual income, marital status, and number of dependents including yourself?
- 5. Describe how your background is relevant to your interest in pursuing a nursing career. Do you see your background as an advantage, disadvantage or both?
- 6. What kind of work would you like to do immediately after graduation?

PART **F** – **APPLICATION CERTIFICATION**

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application.

I also understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I also understand that my personal statements and pictures become the rights of the Health Professions Education Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Printed name (last name, first name, middle initial)

Applicant's Signature	 Date	
11		

SUBMIT APPLICATIONS TO:

Health Professions Education Foundation Kaiser Permanente Allied Health Program 818 K Street, Suite 210 Sacramento, CA 95814

Spring Postmark DEADLINE March 26, 2003 Fall Postmark DEADLINE September 11, 2003

APPLICATION CHECKLIST (Scholarships)

1. One (1) official transcript related to your allied health education.	
2. Personal Statements.	
\square 3. Two letters of recommendation.	
4. Graduation Date Verification Form.	
5. Student Aid Report (SAR).	

☐ 6. Two copies of the original application and the attachments

(items 2-5). Do not make photocopies of transcripts.

Graduation Date Verification Form



*Must be completed by the program director or the director's designee.

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered. Please return this form to the Foundation with original signature.

Applicant's Name:

Allied Healthcare Program:	
Address:	
Year Entered: Month/Year	Expected Graduation Date: Month/Year
Please comment on the student's p	performance and potential for academic success.
Name (Please Print)	Title
Signature	Date
Phone Number ()	
Please check one: ☐ I certify that I am the Pro ☐ I certify that I am authori behalf of the Program Dir	ized to sign this document on

Kaiser Permanente Allied Healthcare Scholarship Program

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